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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13678

CERTIFICATE OF DEATH

13682

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON		c. LENGTH OF STAY IN 1b life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) MARTIN First GREEN Middle BETTS Last		4. DATE OF DEATH Month Oct Day 16 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 9, 1905
9. AGE (In years last birthday) 62 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) fire fighter		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME ARTEMUS W. BETTS		14. MOTHER'S MAIDEN NAME ELNORA GREEN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO.	
17. INFORMANT Address MRS BEATRICE BETTS DENTON			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2000 Reticulum cell sarcoma DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 8 min	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2/6/67 , 19 67 , to 10/16/67 , 19 67 , that (I) (we) last saw the deceased alive on 10/16/67 , 19 67 , and that death occurred at 555 M, from causes and on the date stated above.			
22a. SIGNATURE Philip P. Felipe		22b. DATE SIGNED 10/18/67	
22c. PHYSICIAN'S NAME (Type) Philip P. FELIPE		22d. ADDRESS DENTON, MD	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF Oct 19, 1967	23c. NAME OF CEMETERY OR CREMATORY DENTON	23d. LOCATION (City or Town) (County) (State) DENTON MD
24. FUNERAL DIRECTOR CHARLES V. MOORE ADDRESS DENTON		25a. REC'D BY REGISTRAR DATE OCT 20 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

1911

CERTIFICATE OF DEATH

1911

Name of Deceased		Sex		Age		Date of Death		Place of Death	
John Doe		Male		35		Jan 15 1911		New York City	
Cause of Death		Disease		Occupation		Residence		Burial Place	
Heart Disease		Myocarditis		Teacher		123 Main St		Catholics	
Time of Death		Place of Death		Cause of Death		Disease		Occupation	
10:30 AM		Home		Heart Disease		Myocarditis		Teacher	
Signature of Physician		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Place of Certificate		Cause of Certificate		Disease of Certificate		Occupation of Certificate	
Jan 15 1911		New York City		Heart Disease		Myocarditis		Teacher	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE VITAL RECORDS ACT OF 1908, AND THE DEATH OF THE DECEASED IS PROVED BY THE SIGNATURE OF THE PHYSICIAN, REGISTRAR, WITNESS, OR DECEASED, OR BY THE SIGNATURE OF THE FAMILY.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13673

CERTIFICATE OF DEATH

13683

1. PLACE OF DEATH a. COUNTY <u>CAROLINE</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CAROLINE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>DENTON</u>		c. LENGTH OF STAY IN 1b <u>7 yrs</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <u>EMMA</u> First <u>LAVERDA</u> Middle <u>BYE</u> Last		4. DATE OF DEATH <u>Oct 22</u> 19 <u>67</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 8, 1895</u> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTH PLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>SAMUEL BYE</u>		14. MOTHER'S MAIDEN NAME <u>ADA MACKAY</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MALECOLM BYE, DENTON, MD.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CACITEXIA - WIDESPREAD METASTASES</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>CARCINOMA BREAST - FIRST OPERATED 1935</u> DUE TO			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>NONE</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>JAN. 21, 1960</u> , to <u>OCT 22, 1967</u> , that <u>TH</u> (we) last saw the deceased alive on <u>OCT 21, 1967</u> , and that death occurred at <u>AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Robert Howard Wright</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>OCT. 23, 1967</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROBERT HOWARD WRIGHT MD</u>		22d. ADDRESS <u>GREENSBORO MARYLAND</u>	
23a. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>OCT 25, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>SHARP'S</u>	23d. LOCATION (City or Town) (County) (State) <u>FAIR HILL, CECH, MD.</u>
24. FUNERAL DIRECTOR <u>CHARLES MOORE DENTON, MD.</u> ADDRESS		25a. REC'D BY REGISTRAR <u>Charles Judge</u> DATE <u>OCT 26 1967</u>	25b. REGISTRAR'S SIGNATURE

13823

13823



UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT
WASHINGTON, D. C. 20250
OFFICE OF THE ASSISTANT ATTORNEY GENERAL
WASHINGTON, D. C. 20540
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

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2

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13680

CERTIFICATE OF DEATH

13684

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DENTON		c. LENGTH OF STAY IN 1b 40 yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) HARVEY MARVEL COLLINS		4. DATE OF DEATH Month Oct Day 23 Year 1967	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 29, 1884
9. AGE (In years last birthday) 83 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MGR. ICE MAKING	
11. BIRTHPLACE (County & State, or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOSEPH J. COLLINS		14. MOTHER'S MAIDEN NAME B. M. A. WORKMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Harvey Collins Denton		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Toxemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) gangrene, severe left toe DUE TO (c) arteriosclerotic stenosis, left b. lateral			INTERVAL BETWEEN ONSET AND DEATH years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/19/66 19, to 10/22/67 19, that (I) (we) last saw the deceased alive on 10/22/67 19, and that death occurred at 2:00 A.M. from causes and on the date stated above.			
22a. SIGNATURE Chas. Moore		22b. DATE SIGNED 10/25/67	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Oct. 27, 1967	23c. NAME OF CEMETERY OR CREMATORY ODD Fellows	23d. LOCATION (City or Town) (County) (State) Laurel Delaware
24. FUNERAL DIRECTOR Charles Moore Denton, Md.		25a. REC'D BY REGISTRAR DATE OCT 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

24542

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13681

CERTIFICATE OF DEATH

13685

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro			c. LENGTH OF STAY IN 1b 66 Yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Goldsboro		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None				d. STREET ADDRESS None		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Myrtle Groce Matthews				4. DATE OF DEATH Month Oct. Day 20 Year 1967			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 16, 1901		9. AGE (In years last birthday) 66 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Charles Groce				14. MOTHER'S MAIDEN NAME Heneretta Hazelton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 220-03-9918		17. INFORMANT 307 W. 153rd. Street Marie Giles New York City, N.Y.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Failure 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Disease DUE TO (c) Arteriosclerotic C.V.Dis.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Chronic Arthritis, Obesity							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 1967 , to Oct. 20, 1967 , that (I) (we) last saw the deceased alive on Oct. 20, 1967 , and that death occurred at 210A M. from causes and on the date stated above.							
22a. SIGNATURE <i>Charles H. Stonesifer</i>				22b. DATE SIGNED Oct. 21, 1967		22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.	
22d. ADDRESS Greensboro, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 10-23-67		23c. NAME OF CEMETERY OR CREMATORY Union		23d. LOCATION (City or Town) (County) (State) Goldsboro, Maryland	
24. FUNERAL DIRECTOR J. E. Boulois Greensboro, Md.				25a. REC'D BY REGISTRAR OCT 24 1967		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE ARMY

13050

EXHIBIT 100

Caroline

Weyland

Caroline

John Goldstone

82

John Goldstone

John

John

67

Oct.

Marshall

Group

Apple

Apr. 18, 1901

x

Oct.

Female

100

Henry

John

Honorable

Honorable

Charles Groce

307 W. 12th Street

250-02-2812 Marie Alice New York City, N.Y.

John Goldstone

John Goldstone

John Goldstone

John Goldstone

Oct. 20

Oct. 20

Oct. 20

Oct. 20

Oct. 20

Oct. 20

John Goldstone

John Goldstone

John Goldstone

John Goldstone

Oct. 20

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13682

CERTIFICATE OF DEATH

13686

1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural			c. LENGTH OF STAY IN 1b 50 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Federalsburg - Rural			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Bridgeville Road				d. STREET ADDRESS Bridgeville Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First PURNELL Middle STANLEY Last STANLEY				4. DATE OF DEATH Month October Day 1 Year 19 67				
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 23, 1904		
				9. AGE (In years lost birthday) 62 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer			10b. KIND OF BUSINESS OR INDUSTRY Maryland Plastics		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Harrison Stanley				14. MOTHER'S MAIDEN NAME Lurenda Butler				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No			16. SOCIAL SECURITY NO. 218-14-4013		17. INFORMANT Goldie M. Stanley, Federalsburg, Md., RFD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 9-5-67 , 19 to 10-1-67 , that (I) (we) last saw the deceased alive on 10-1-67 19, and that death occurred at 7:30AM , from causes and on the date stated above.								
22a. SIGNATURE <i>Frank M. Anderson</i>				22b. DATE SIGNED 10-2-67		22c. PHYSICIAN'S NAME (Type) Frank M. Anderson M.D.		
				22d. ADDRESS Federalsburg, Md. 21632				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 7, 1967		23c. NAME OF CEMETERY OR CREMATORY Federal Hill Cemetery		23d. LOCATION (City or Town) (County) (State) Federalsburg, Maryland		
24. FUNERAL DIRECTOR <i>J. J. Frampton</i>				25a. REC'D BY REGISTRAR OCT 10 1967		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>		

1388

Caroline

Federalburg - Rural

50 years

Frederick - Rural

Bridgetown Road

Bridgetown Road

RUSSELL

STANLEY

Oct. 1917

Dec. 23, 1904

Male

Laborer

Maryland Electric

Frederick Co., Md.

Harrison, Stanley

Lumber Dealer

218-14-4013

Oldie M. Stanley, Federalburg, Md.

1904-1917

10-1-17

10-1-17

10-1-17

10-1-17

x

Frederick, Maryland

Oct. 1, 1917

J. L. Harrison & Son, Federalburg, Maryland

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MD
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

13683

CERTIFICATE OF DEATH

13687

1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PRESTON, RURAL		c. LENGTH OF STAY IN TB 10 YRS.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) RFD #1, BOX 40		d. STREET ADDRESS RFD #1, BOX 40	
3. NAME OF DECEASED (Type or print) First AUGUSTUS Middle DAVID Last WEBB		4. DATE OF DEATH Month OCTOBER Day 19 Year 19 67	
5. SEX MALE	6. COLOR OR RACE NEGRO	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5, 1887
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING	
11. BIRTHPLACE (County & State, or foreign country) CAROLINE COUNTY, MD.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME AUGUSTUS WEBB		14. MOTHER'S MAIDEN NAME RENE ANNE JONES	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. 216-54-9097	
17. INFORMANT MRS. MARY JEFFERSON, PRESTON, MD. RFD #1		Address BOX #4 40	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Cardiac Decompensation DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Generalized arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 10 yrs 15 yrs 20 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Loss of Left Leg Arteriosclerosis Gangrene Rt Great Toe			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12/21/50 , 19__, to 10/19/67 , 19__, that (I) (we) last saw the deceased alive on 10/11/67 , 19__, and that death occurred 12/4/67 from causes and on the date stated above.			
22a. SIGNATURE Harold B. Plummer		22b. DATE SIGNED 10/23/67	
22c. PHYSICIAN'S NAME (Type) Harold B. Plummer M.D.		22d. ADDRESS Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF OCT. 22, 1967	23c. NAME OF CEMETERY OR CREMATORY JOHNS CHURCH CEMETERY	23d. LOCATION (City or Town) (County) (State) NR. PRESTON, CAROLINE, MD.
24. FUNERAL DIRECTOR FRAMPTON FUNERAL HOME, FEDERALSBURG, MD.		25. REC'D BY REGISTRAR DATE OCT 27 1967	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

10000

CAROLINE

DECEASED

WED 41 BOX 40

AUGUST 2

WED 41

RETIRED CAROLINE

AUGUST 2 1967

NO

110-22-2001

WED 41

WED 41

WED 41 BOX 40

DECEASED

CAROLINE

CAROLINE

CAROLINE COUNTY, MD.

WED 41 BOX 40

WED 41 BOX 40

WED 41

WED 41

WED 41

OCT. 27, 1967 JOHN'S CHURCH CEMETERY

WED 41 BOX 40